State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
January 19, 2016, 4:30 P.M. to 6:00 P.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Attendance
Members
Co-Chair Commissioner Kathleen Hittner, Al Kurose, Hub Brennan, Al Charbonneau, David Feeney, Howard Dulude, Karl Brother, Sam Salganik (for Tina Spears), Mike Souza, Bill Schmiedeknecht

Not in Attendance
Co-Chair Steve Boyle, Gregory Allen, , Tammy Lederer, William Martin, David Mathias, Wendy Mackie, Pat Mattingly, Rob Cagnetta, Vivian Weisman, Emmanuel Falck

Issuers
Neighborhood Health Plan of Rhode Island: Emily Colton
Blue Cross Blue Shield of Rhode Island: Gus Manocchia, Megan Dennen
UnitedHealthcare: Lauren Conway
Aetna: Ron Souza
Delta Dental of Rhode Island: Kerrie Bennett

State of Rhode Island Office of the Health Insurance Commissioner
Linda Johnson, Sarah Nguyen, Cory King, Jay Garrett

Minutes

1. Welcome and Review of December Meeting Minutes
Commissioner Hittner called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance. Karl Brother moved to accept the minutes from the December 17th, 2015 meeting and Sam Salganik seconded. The minutes were approved unanimously with no changes. Dr. Hittner noted that the handouts included a press release about the "Choosing Wisely" grant that the Rhode Island Business Group on Health (RIBGH) recently received. Al Charbonneau described the grant: "Choosing Wisely" was a program started by the American Board of Internal Medicine Foundation, partnered with Consumer Reports, to help consumers make better choices and to eliminate waste in the healthcare system. The RIBGH signed a partnership agreement with Consumer Reports a year ago and the Rhode Island Foundation has given the RIBGH a small grant for this purpose. A steering committee will be established to help roll this out and the program will provide links, videos, and promotional information free of charge. The information is well-vetted and evidence based. Mr. Brother asked if this is something that the state of Rhode Island should consider supporting. Mr. Charbonneau responded this program can have a near-term impact on costs and that he has been talking to stakeholders about declaring Rhode Island a "Choosing Wisely" state.

2. RIREACH

Sam Salganik, RIPIN, introduced the new manager of the RIREACH program – Karina Gibbs. Ms. Gibbs was previously with HealthSource RI (HSRI) at the walk-in center for two years and prior to that she worked for Neighborhood Health Plan of Rhode Island. Going forward, Ms. Gibbs will be representing RIPIN at HIAC. Mr. Salganik delivered the RIREACH consumer update. RIREACH saw 2900 cases this year, cases specific to health insurance problems saw an increase of 20% over the prior year which indicates that the program is growing. Mr. Brother asked how the open enrollment period is progressing. Mr. Salganik replied that renewals for HSRI are going much better than last year and that the passive renewal approach has generally worked. There have been a small handful of issues for clients with unusual information or circumstances. There have been long hold times at the call center but that is to be expected given the deadline for open enrollment is fast approaching.

3. Health Reform Update

State Innovation Model (SIM): SIM Director Marti Rosenberg reported updates in three areas with regards to the SIM project. First, she noted that Melissa Lauer will be starting on January 24th as the Health Information Technology Specialist, located at EOHHS. A formal offer has been made and accepted for the Chief of Behavioral Health Transformation at BHDDH and there were interviews for the position at the Department of Health. HSRI received resumes for their SIM position and there were a large number of applicants. Ms. Rosenberg indicated that she expects an announcement for the project management vendor soon. Second, she discussed how the SIM Steering Committee is in the process of making funding decisions – there will be another meeting will be on January 28th to dig in more deeply and review the allocations of funding. She anticipates that funding decisions will be made by February and March. The State owes the federal government an operational plan by the end of April so staff are working on the driver diagram (a logic model) and fleshing out the theory of change. All materials are up on the EOHHS website. Third, Ms. Rosenberg noted that one of the goals of SIM was to not only align state agencies but also to align the state with entities outside government so that there is a unified approach to payment reform. To this end, there was a recent meeting with Medicaid and OHIC to align payment reform goals. Additionally, Ms. Rosenberg has met with the Rhode Island Quality Institute to ensure that the work they are doing on the Transforming Clinical Practices Initiative aligns with SIM.

Dr. Hittner asked Ms. Rosenberg to comment on the inventory that she and staff are pulling together. Ms. Rosenberg responded that there are a lot of entities doing work for payment reform and care transformation so there was a need to better understand where money is already being spent and where money has not been spent to ensure that duplication of funding does not occur. Dr. Hittner noted that such an inventory will give a good picture of the existing projects and will allow the State to maximize opportunities.

Governor's Working Group for Healthcare Innovation

Commissioner Hittner asked Cory King, OHIC, to explain the progress on a premium and medical trend study mentioned in the Working Group's final report. Mr. King responded the study is intended to help stakeholders better understand the relationship between growth in medical expense and growth in premiums. Data were compiled since 2011 from the rate filings which included OHIC approved premiums and medical expense trend. At this point, the study cannot account for changes in benefit structure throughout the years and we know from the commercial market that there is a substantial migration to plans with higher cost sharing. The study is also drawing data from federal Medical Loss Ratio (MLR) reports to have a better sense of where premium dollars going, including allocation towards

taxes, fees, quality improvements, and administrative expenses. Mr. King indicated that there will be a draft of the study in the next month. He noted that there was a striking increase in the number of federal taxes between 2013 and 2014 due to ACA. For example, Blue Cross (across all lines of business) had their taxes increase from 40 to 70 million which was likely reflected in subsequent rate increases. Mr. King also noted that the study could be used to evaluate OHIC's effectiveness with regards to rate approvals and premium trend. Dr. Hittner asked about the structure of the taxes and who they applied to. Sarah Nguyen, OHIC, replied that there were a variety of taxes and fees included in the passage of the ACA: some taxes were permanent while other were temporary, some applied to the fully-insured market while others included the self-insured market as well – this is something that they study can examine more closely. Dr. Hittner noted that it was very important to understand the elements of premium that we can control and the elements that we cannot control. Hub Brennan noted that he assumed that the movement towards increased cost-sharing would have a downward effect on premium trend and that OHIC can only act (for rate approvals) on information they have received from the carriers – what happens in the market outside of that may be outside of OHIC's control in terms of the rate review process.

Mr. Charbonneau noted that he felt that premiums have been affordable for 5 to 10 years so bending the rate of increase two years into the future would not make as much of a difference with regards to overall affordability.

Dr. Al Kurose clarified that the idea of looking into premiums from the past few years was prompted, in part, by the Wakely Total Cost of Care (TCOC) study which showed a flat medical trend – the goal of the study was to understand the relationship between medical cost trend and premium trend. Mr. King noted that the TCOC blended fully-insured and self-insured medical trends and that in the case of the premium study, fully-insured trends were higher than self-insured trends for that time period.

Mr. Brother asked that OHIC find some way to factor in the dramatic increase consumers have seen in co-pays and deductibles. Mr. King responded that he didn't have an answer as to how OHIC could factor that issue into the current study but that OHIC monitors compliance in other areas (e.g. large group trends). The current analysis does not control for the fact that people are buying "leaner" plans. Mr. King also noted that the carrier MLRs are high.

Dr. Kurose suggested that perhaps data through the APCD or other some other source could be examined to look at the efficacy of ACOs. Mr. King responded that that this would be good to do as part of SIM process and that performance across different types of providers could be analyzed.

Governor's Council on Behavioral Health

Dr. Hittner discussed OHIC's recent presentation at the Governor's Council on Behavioral Health on the current OHIC market conduct exam on mental health parity. Since the conduct exam is ongoing, the presentation focused on the purpose of the exam and the methodology. Dr. Hittner also noted that during the presentation, she emphasized that mental health parity does not mean that everything relating to mental or behavioral services is paid for – if there are necessity rules on the medical side, there may be corresponding necessity rules on the mental health side.

4. Primary Care Spend Report

Mr. King presented on OHIC's primary care spend report, including examining the period between 2010 and 2014 and looking at how primary care spend has changed over the first wave of the Affordability Standards. This first wave required carriers to increase the amount of primary care spend by 1% per year over a five year period and allowed "credit" for primary care based initiatives, such as payments to patient-centered medical homes (PCMHs). Mr. King explained that the increase in primary care spend has not traditionally gone into fee schedules, rather it has gone into funding for PCMHs and incentive payments for primary care providers – OHIC never intended for insurers to meet their primary care target by raising fee schedules. For the second phase of the Affordability Standards, OHIC plans to examine high-performing health plans and look at the percentage of their total medical spend that is devoted to primary care – Milbank is performing that analysis and can tell us how Rhode Island compares to other health plans across the country. Mr. King anticipates that the primary care spend report will be published in the next few weeks.

Mr. Brennan noted that one of the original goals of this primary care spend target was to create an attractive environment for primary care physicians – are we currently working to achieve that goal?

Dr. Gus Manocchia, BCBSRI, mentioned that Blue Cross has been involved in this work for the last 7 to 8 years and that he agreed with Mr. Brennan that improving physician satisfaction was part of the four main goals (others were affordability, quality, and patient experience). He noted that we have yet to see all of the potential impact from the PCMH model and that more outcomes will materialize with the continued coordination of primary care practices. In terms of money, Dr. Manocchia noted that the increased money going into primary care has had a positive impact on primary care incomes – this may have occurred at the expense of specialist incomes and to some degree, hospitals. Dr. Kurose responded that the Affordability Standards have been crucial to what has been developed at Coastal and that the full potential of these new models of care has not yet been realized.

Mr. Charbonneau mentioned that while on the topic of costs, some members of HIAC came from the Health Services Council meeting and that there is an emergency department company who is trying to come to Rhode Island to build a freestanding emergency department. There is a law that goes back to 1981 which exempts freestanding EDs from certificate of need requirements. Mr. Charbonneau felt strongly that should this company be allowed to build its freestanding ED, many of the efforts around affordability or healthcare reform would be compromised. Committee members further discussed the potential implications of a new freestanding ED in Rhode Island.

5. 2017 Care Transformation and Alternative Payment Methodology Plans

Mr. King presented on the fall convening for the Alternative Payment Methodology Committee and draft 2017 plan. He noted that there is a national movement around alternative payments and that last week the Healthcare Payment Learning and Action Network convened by CMS released a draft framework for defining and classifying alternative payment models. The work that OHIC is pursuing is consistent with that APM framework. OHIC wants to have 80% of payments tied to value by 2018 and 50% of payments in alternative payment models by 2018.

Ms. Nguyen presented on the work of the fall Care Transformation Committee and summarized the four major components of the plan: modifications to the definition of a PCMH, the PCMH target for 2017, financial payment model, and activities to promote PCMH adoption. She discussed a few stakeholder

comments that OHIC had received, including questions about the relationship between PCMHs and ACOs and next steps for implementation.

6. Public Comment

There was no public comment.